

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	<p>This visit was for the Investigation of Complaint IN00128639.</p> <p>Complaint IN00128639 - Substantiated. Federal/state deficiencies related to the allegations are cited at F353.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey and the Investigations of Complaints IN00127149, IN00127770, IN00127927, IN00128370.</p> <p>Survey dates: April 30, May 1,2,3, 6, 7, 8, and 9, 2013</p> <p>Facility number: 010996 Provider number: 155665 AIM number: 200232210</p> <p>Survey team: Diana Sidell RN TC Gordon Tyree RN</p> <p>Census bed types: SNF: 9 NF: 50 SNF/NF: 44 Total: 103</p> <p>Census payor type:</p>	F000000	This tag is a duplicate tag that has already been accepted in the POC for the annual 2013 survey with this tag attached to the annual 2567.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Medicare: 9 Medicaid: 78 Other: 16 Total: 103</p> <p>Sample: 7</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 5/17/13 by Suzanne Williams, RN</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013	
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000353 SS=E	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, record review, and interview, the facility failed to provide sufficient nursing staffing to meet the needs of the residents. This affected Residents #F, E, A, and had the potential to affect all 103 residents residing in the facility.</p> <p>Findings include:</p> <p>1. Dressing change observations were done on 5/8/13 at 10:39 a.m., with LPN #6, for Resident #F. The dressing that was removed from the</p>	F000353	This is a duplicate tag, please see annual with complaint for identical tag/answer, which has already been approved.1. a) Resident F: wound on lower buttock was cleansed and a clean dressing applied; tracheostomy area was cleansed and a clean dressing applied.b) Resident E: G tube site cleansed and dressing applied.c) Resident A: restorative plan for active range of motion to bilateral upper and lower extremities and restorative plan for transfers and ambulation will be followed as written per care plan. The restorative aide	06/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>left lower buttock was dated 5/7/13 on the 6 a.m. - 2 p.m. shift. The dressing that was removed from the tracheostomy was dated 5/7/13 on the 6 a.m.-2 p.m. shift. When queried about dressing change times, LPN #6 indicated the dressing should have been changed on the second shift the night before.</p> <p>Resident #F's record was reviewed on 5/3/13 at 12:40 p.m. The record indicated Resident #F was admitted with diagnoses that included, but were not limited to, respiratory failure and pneumonia.</p> <p>Current physician's orders dated 5/1/2013 through 5/31/2013, indicated Resident #F's dressing to the left lower back was to be changed twice a day once on the 6 a.m. to 2 p.m. shift and once on the 2 p.m. to 10 p.m. shift.</p> <p>2. A dressing change observation was done with LPN #6 on 5/8/13 at 11:47 a.m., on Resident #E, and the dressing removed from the gastrostomy tube site was dated 5/7/13 on the 6 a.m. - 2 p.m. shift. LPN #6 indicated the dressing was supposed to be changed twice a day</p> <p>Resident #E's record was reviewed</p>		<p>will only be involved in restorative programming.d) The facility will advertise with newspapers in the surrounding counties to recruit nursing staff.2. a) All residents have the potential to be effected by the alleged staffing concerns.b) The facility completed an audit on 5/22/13 of all resident dressing changes, and any concerns of dressing changes were immediately addressed.c) A 100% audit of resident files completed for residents receiving restorative programming to ensure that restorative programming is completed as indicated in resident care plans.3. a) All nursing staff were in-serviced on 5/17/13 that physicians orders must be followed as to cleansing and changing all resident dressings.b) Nursing staff was in-serviced on facility policy and procedure for restorative programming and to the facility policy that the restorative aide will be designated to perform only restorative programming. 4. a) Director of Clinical Services and/or designee will perform an audit daily on each unit to ensure that all dressing changes are completed per M.D. orders for a period of 2 weeks; then 3 times per week on each unit for 2 weeks; then weekly on each unit for 2 weeks; then weekly on a random unit for one month, then randomly on different units for one month, until it has been</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>on 5/9/13 at 4:15 p.m. The record indicated Resident #E was admitted with diagnoses that included, but were not limited to, stroke, locked in state, quadriplegia, difficulty swallowing, chronic pain, anxiety, and did not speak.</p> <p>Current physician's orders dated May 1 through May 31, 2013 indicated Resident #E's gastrostomy tube site was to be monitored twice a day, and Zinc oxide cream applied around the site and change the dressing twice a day on the 6 a.m. to 2 p.m. shift and on the 2 p.m. to 10 p.m. shift.</p> <p>3. Resident #A's record was reviewed on 5/6/13 at 7:58 a.m. The record indicated Resident #A was admitted with diagnoses that included, but were not limited to, urinary retention, eye dryness, constipation, anemia, overactive bladder, bladder spasms, heart disease, and wound healing.</p> <p>Physician's activity orders, dated for May 2013, indicated "Activities as tolerated." Will do therapeutic work as desired.</p> <p>A care plan for restorative indicated: "Program - AROM (Active range of motion) BUE (bilateral upper</p>		<p>determined by the QA committee that the issue has been resolved.b) The MDS coordinator/designee will audit weekly to ensure that restorative programs are completed on a daily basis. The results of the audits will be reviewed in the monthly QA meeting, and Quarterly with the Medical Director.c) The staffing ratio will be reviewed daily in the a.m. meeting to ensure that adequate staff is available.5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our completion date is 6/8/13.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>extremities)/BLE (bilateral lower extremities), /Transfers/Ambulation. Goal & Target Date: Resident will participate in restorative program. Resident will transfer safely from surface to surface w (with)/staff assist and appropriate equipment. Approaches: ROM (range of motion) to Bue/Ble 15 reps tid (three times a day), (Resident #A) to ambulate 50-100 ft w (with) rww (rolling walker) and 1 assist w leg braces on bilateral legs (Resident likes to put them on herself), Orient to task at hand. Use simple, brief statements, Call by Proper name, Use visual cues with verbal cues, Encourage use of adaptive equipment such as eye glasses, dentures, hearing etc. Do not exceed point of pain. See Restorative flow sheets for specific approaches. Check for skin break down in creases of hands, elbows, axillary, popliteal and groin areas. Do not attempt ROM when resident is agitated or resistive to care. Re-approach. Praise for al participation.</p> <p>A restorative nursing care plan indicated the resident was supposed to Ambulate 250 feet each day as tolerated, 7 days a week with rolling walker and a w/c following. She is also to attend a.m. exercise class for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013	
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>active and passive range of motion with verbal cues, and hands on as needed.</p> <p>A "Restorative Nursing Care Report" indicated the resident missed 8 days of restorative walking in April, between April 1-30, and 2 days of restorative walking in May between May 1-9, 2013.</p> <p>During an interview, on 5/9/13 at 4:26 p.m., CNA #3 indicated Resident #A didn't get to walk on Tuesday May 7, and Wednesday May 8. She said sometimes she doesn't get to walk quite a bit because the restorative aide is pulled to help on the halls. She also said it is a "whole days work" to walk everyone who is supposed to be walked.</p> <p>A policy and procedure for "Restorative Nursing" was provided by the Director of Nursing on 5/9/13 at 6:17 p.m. The policy indicated, but not was not limited to, "Team Members & Their Roles...Restorative Aides: The designated Restorative Aides follow the plan, developed by the team, and provide the direct care needs of the resident. The Aides will be responsible for the documentation of the care given...Restorative Staff...Designated Restorative Aides;</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Provide programming, document programming. Administrative Staff: Ensure back-up for Restorative Aides. Do not pull Restorative Aides to floor for general care...."</p> <p>4. During an interview on 5/6/13 at 5:15 a.m., CNA #7 indicated on her hall she has 28 residents with one CNA during the night. She said she stays busy and is usually here a half hour to an hour past her shift because she has so many people to get up and get dressed, and has to get help with the two person assists. She said the charge person on her hall helps her when she needs help.</p> <p>During an interview on 5/6/13 at 5:55 a.m., LPN #8 indicated they have been short nurses and aides, but "they just got agency in here and it's been better."</p> <p>A family member who wished to be anonymous, indicated that sometimes they have to wait two hours for staff to change their family member who was wet and soiled. Also, there is one aide on the floor for each hall during the evening at times, and wonders how one person can turn residents when they need two to be turned. The aide has to go to another hall to get help.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>During an interview on 5/9/13 at 1:50 p.m., Corporate Nurse #1 and Corporate Nurse #2 indicated they have been given permission to give a wage increase. They are working on the "per patient day" staffing ratio which is 3.10 staffing hours per patient per day, this includes nursing, QMAs, CNAs, and restorative aides. They indicated they are putting ads in newspapers in the surrounding counties to recruit nurses.</p> <p>This Federal tag relates to Complaint IN00128370.</p> <p>3.1-17(a)</p>				